PIONEER ACO MODEL–
JOURNEY INTO THE UNKNOWN

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OBJECTIVES FOR TODAY

• Understand the benefits/risks of the Pioneer ACO

• Lessons learned & tools we have utilized

• How to position YOUR organization to be a trusted provider
OBJECTIVES FOR TODAY

Get comfortable being uncomfortable

There is never an END point, you have never “arrived” our world is constantly changing and evolving.

Don’t catch up – get ahead and keep pushing further!

ACCOUNTABLE CARE ORGANIZATION (ACO)

An ACO is a group of doctors, hospitals, and healthcare providers working together with Medicare to give you better service and care

Several ACO Programs:
- Medicare Shared Savings Program
- Advance Payment ACO Model
- **Pioneer ACO Model**
- Next Generation ACO Model
ACO TRIPLE AIM (GOALS)

- Better Experience
- Better Health
- Better Value

PIONEER ACO MODEL

Trinity Pioneer ACO:
- Northwest Central Iowa
- 10,000 Attributed Members
- Shared Savings
  - 2012: $0
  - 2013: $1,218,812
  - 2014: TBD
- 2013 Quality Score = 86%

19 organizations participating in the Pioneer ACO Model in PY4 (CY2015):
ACO PARTNERSHIP

- Critical Access Hospitals
- Community LTC Facilities
- Home Care/Hospice
- Public Health Agency
- Federally Qualified Healthcare Centers
- Area Agency on Aging
- Iowa Medicaid contractors
- Iowa Pharmacist Association

PARTNERSHIP GUIDING PRINCIPLES

- **Partner** with providers who deliver quality care and outcomes
- **Collectively** define goals and plan to deliver ACO strategy
- **Identify** resources to support ACO strategy
- **Engage** operations in adaptive design performance improvement to eliminate barriers to delivering strategy

Integration is more about leadership, risk taking, relationships, and personality than it is about a specific formula or process to be followed.
TRINITY PIONEER ACO
FUNCTION IS THE STRATEGY – OPERATIONAL CAPACITY AND CULTURAL APPETITE IS THE EXECUTION

- Science of Change – Adaptive Design
- Approaching Chronic Care with a common language – ICCDM
  - Integrated Chronic Care Disease Management
- Finding Leaders and Providers and Teams dedicated to the vision
  - Chemistry is important – so is forgiveness
  - SMEs have a role
  - Collaborators get the most done
  - The work gets more complicated, so stamina is an important attribute of people doing the work
  - Telling and sharing experiences and patient stories reenergizes the work
- It is not a “program” thus the work will never end

WHAT DOES PARTNERSHIP LOOK LIKE

True spirit of collaboration – the person is in the center of all we do
- Information sharing
- Pilot programming
- Investment
- Not always “winning”
THINGS TO CONSIDER TO BE CONSIDERED

• Better Experience
  • 24/7 admissions with after-hours options
  • 24 hour RN coverage
  • Use INTERACT or comparable tools
  • Effectively manage transitions between acute and post-acute, and post-acute and home
  • Formalized patient experience program

• Better Health
  • CMS 5-star rating of 3 or higher
  • Lower 30-day hospital re-admission rates
  • On-site provider(s) by 2017

• Better Value
  • Lower costs by reducing average lengths of stay
  • Transition patients home sooner at the highest possible level of function

Changing the “when in doubt, send ‘em out” way of thinking

TOOLS WE USE

Interact Tools: SBAR, Care Pathways
Readmission meetings/phone calls
Shared care plan conferences/“huddles”
Quarterly SNF/hospital meetings
Electronic data sharing
IPOST
Wound Care & Palliative Pilots & continued programming
RESULTS/OUTCOMES

Why is collaboration between ACOs and SNFs so important?

- Improve outcomes for patients
- Stabilize Medicare spending now and in the future
- Build a healthier community for the next generation

RESULTS/OUTCOMES

Improve Coordination to Reduce Hospital Utilization

Shifting PAC From More Expensive Services to Less Expensive

Identify Unnecessary or Low Value PAC Services
**SNF 3-DAY WAIVER**

- Establish preferred network
- Create process for screening & referring patients
- Develop and train interdisciplinary team
- Educate staff about process and new roles
- Measure and track performance

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### SNF 3-DAY WAIVER

<table>
<thead>
<tr>
<th></th>
<th>Direct Admissions (without an inpatient stay)</th>
<th>Inpatient hospitalization &lt;3 days</th>
<th>Non-Waiver Patients</th>
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</thead>
<tbody>
<tr>
<td>SNF Admits (#)</td>
<td>47</td>
<td>13</td>
<td>581</td>
</tr>
<tr>
<td>ALOS (days)*</td>
<td>18.1</td>
<td>17.8</td>
<td>21.6</td>
</tr>
<tr>
<td>Hospital Admissions within 30-days (%)</td>
<td>11%</td>
<td>23%</td>
<td>18%</td>
</tr>
<tr>
<td>SNF Readmission within 30-days (%)</td>
<td>15%</td>
<td>8%</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Reducing one day = $256,720 annual savings*

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CMS Claims Data 2014 Q2 – 2015 Q1
PATIENT STORY

Q&A
SUPPORT MATERIAL

LOGOS

UnityPoint Health
Fort Dodge

UnityPoint Health
TRINITY PIONEER ACO

UnityPoint Health
Fort Dodge

ACO Triple Aim

Better Experience
Better Health
Better Value
CENTER FOR MEDICARE AND MEDICAID

- **Purpose**: To test innovative payment and service delivery models that improve health and reduce costs
  - Patient Care Models
  - Seamless, Coordinated Models
  - Community and Population Health Models
- **Result**: Successful models will be spread nationwide.

We need to Fix This!

**U.S. HEALTHCARE IS ONLY EXPENSIVE WHEN YOU USE IT!**

PURPOSE OF THE PIONEER ACO

• Triple Aim Goals:
  • Better care for individuals
  • Better health for populations
  • Reduced healthcare expenditures

• Payment Reform Characteristics:
  • Transition from Fee For Service
  • Generate Medicare savings

The Case for Care Coordination

Medicare Spending

Payment Reform Characteristics:

Continuum of Relationships and Payment Options

- Shared Savings
- Full Capitation
- Bundles
- Medical Home
- Pay for Performance
- Fee For Service
The Case for Care Coordination

Accountable Care Organization (ACO) Model

- Projected cost based on medical inflation trends
- Actual costs based on ACO and Medical Home collaboration
- Performance Incentives for Physicians & Hospitals
- $ - SAVINGS FOR EMPLOYER/PAYOR

UnityPoint Trinity Pioneer ACO

Understanding the Financial Costs

- Put the Patient at the Center
- Put the Population Strategy in place to get the impact

Then understand how the financial impact will flow
### POST-ACUTE CARE PARTNERS

#### Four Sites of Care:
- Inpatient Rehab Facilities (IRF)
- Skilled Nursing Facility (SNF)
- Long-term Acute Care (LTAC)
- Home Health Agencies

#### Other Levels of Care:
- Intermediate Care Facilities (ICF)
- Assisted Living Facilities (ALF)
- Independent Living Facilities (ILF)
- Palliative Care
- Hospice

### IMPROVE COORDINATION TO REDUCE HOSPITAL UTILIZATION

- Effectively manage transitions
- Develop and implement care pathways and SBARs
- Embed providers (physicians and SNF case manager) in the care team at each SNF
- Collaborate
SHIFTING PAC FROM MORE EXPENSIVE SERVICES TO LESS EXPENSIVE

- **Placement efficiency:**
  - Providers operating at top of license
  - ACUTE → SNF → HOME HEALTH

- **Avoidance of costly acute services:**
  - SNF Waivers
  - Demonstrate higher levels of clinical efficacy

IDENTIFY UNNECESSARY OR LOW VALUE PAC SERVICES

- **Clinically Effective Length of Stay:**
  - Greatest savings potential exists around affecting ALOS in SNF
  - High potential for improvement
PAC Initiatives & Barriers

Desired Outcomes:
- Changing the “when In doubt, send 'em out” way of thinking
- Partnership, Collaboration and Standardization
- Reducing Expenditures through Care Coordination Improvement

Initiatives:
- SBAR
- INTERACT III Tools
- SNF 3-day Waiver
- Home Care after SNF
- Potential for 30-day readmission measures
- IPOST

Barriers/Challenges:
- Geography (31 SNFs in 8 counties)
- Smaller Homes (68% ≤ 60 beds)
- Resources, Expertise & Infrastructure to support...
  - Education & Re-education
  - Standardization
  - “Eyes” on all ACO Benes
  - Measuring Results